Maternal and Child Health Access

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August 19, 2004

Sandra Shewry, Director
California Department of Health Services
Department of Health Services
1501 Capitol Ave. #6086, MS 4000
Sacramento, CA. 95814

Re: Comment on CPR Recommendations

Dear Director Shewry:

Thank you for your letter of August 11, 2004 requesting comment by August 20, 2004 on the California Performance Review (CPR) recommendations affecting the State Department of Health Services and the programs it administers. As the 20th is the same day as the CPR Commission's hearing on the Health and Human Services recommendations, the comments below include several health and other items not referenced in your letter and will also be submitted to the Commissioners.

Integrated throughout our comments are responses to the specific questions posed in your letter:

1. Will the proposal improve access to services? Does it make it simpler for customers or clients?
2. Will the proposal improve delivery of services?
3. Will the proposal improve outcomes?
4. What will be the impact on the service provider network?
5. Will the proposal improve program efficiency?
6. Provide comments on how the proposals could be improved.

The following are the specific CPR items that Maternal and Child Health Access (MCHA) addresses in this letter:

HHS 01 Transform Eligibility Processing
HHS 28 Medi-Cal "Smart Cards" and Finger-Imaging

HHS 27 Automate Identification of Other Health Coverage for Medi-Cal
HHS 30 Medi-Cal TARs
HHS 23 Medical Survey/Health Plan Audits
HHS 02 Realigning (County Health Services)
HHS 10 $50 Child Support Disregard Payments

HHS 01 Transform Eligibility Processing

CPR Recommendation A (HHS 01): *The Governor should work with the Legislature to centralize and consolidate eligibility processing for Medi-Cal, CalWORKs, and Food Stamps at the state level and to follow the model of California's Healthy Families program utilizing a public-private partnership.*

MCHA Comment: This CPR recommendation involves several major policy components: (1) centralizing eligibility determinations at the state level; (2) consolidating eligibility processing for four major benefits programs; (3) using technology in processing applications; and (4) privatizing the administration of the eligibility process, following the Health Families Program model. **This "bundling" gives rise to significant questions and concerns, especially in view of what appears to be a companion proposal to eliminate a significant number of county eligibility technician positions.**

MCHA has long worked to make the application process for Medi-Cal, Healthy Families, and other health programs easier for consumers and the counties and other entities making eligibility determinations, to better serve families and their children and more efficiently use taxpayer dollars. **Modernization through technology continues to be one important part of this work.** Among our most recent efforts is SB 24 (Stats 2003, c. 895), which establishes a Prenatal Gateway for pregnant women to enroll through a new and simplified application process directly from prenatal care providers' offices, using the Internet, and sets up an even simpler electronic Newborn Hospital Gateway. The children's CHDP Gateway computer no longer unlawfully terminates coverage for newborns who are entitled to keep Medi-Cal at least until their first birthdays, and we are working with others to have the grossly inefficient and ineffective paper application process removed entirely from the CHDP Gateway for all the children who attempt to enroll in either Medi-Cal or Healthy Families through that "door." MCHA also actively participates in the *One-e app* development process, initiated by The California Health Care Foundation, for Los Angeles County.

A major concern with the CPR recommendation, however, is the premise that, for all applicants, centralization at the state level with contact through telephone call centers or the Internet can completely replace service provided

by human beings in person at the local level. Accountability to local consumers and effective problem-solving opportunities must be ensured. From our experience with the state's existing "single point of entry" mail-in application process for Medi-Cal for children and pregnant women and Healthy Families, we know the difficulties that a remote, centralized system can entail. Problems would be compounded if every applicant were required to use a call-in center or a computer to apply: many impoverished families do not have access to a P.C., much less an Internet provider, and even their access to telephone service can be unreliable. These and other important access issues affecting the poor, not only in Los Angeles County but throughout the state, must be carefully considered and addressed. **Consumers need to retain the choice to have an in-person visit with a qualified eligibility specialist.**

Another major concern we have is the CPR's silence on the need for assistance not just with the application form but also with successfully completing the *whole* eligibility determination process. Over and over again MCHA finds that getting the application in is often just the beginning of a client's need for assistance: providing follow-up documentation, responding to requests for additional information, resolving delays, and averting mistakes are often required—whether the entity processing the application is the county for Medi-Cal *or* the state's Healthy Families contractor. **Such follow-up is extremely labor intensive and requires adequate staffing.**

Nor would the need for follow-up or local, in-person assistance be completely eliminated by automating additional parts of the eligibility determination process, given the state's current eligibility rules and policies. Disappointingly, the CPR recommendations do not include exercising existing state options to simplify eligibility requirements in Medi-Cal *and* Healthy Families to truly streamline the application processes for both programs and eliminate unnecessary barriers and administrative expense. **One of the greatest application barriers our clients face, and a major administrative burden in the eligibility determination process, results from the current requirements for income verifications. Yet federal law allows paperless verification of income through a variety of methods.** Scanning verification documents as part of an e-application process may mitigate but will not eliminate this burden. **The CPR recommendation could be improved by including paperless verifications as well as state options for avoiding duplicative demands for eligibility verifications of consumers enrolling in Medi-Cal and Food Stamps at the same time.**

The CPR also misses the importance of simplifying the eligibility rules themselves in order to not only make the application process easier for consumers but to maximize the opportunity for modernization and reduction

in administrative expense. For example, pregnant women often miss out on important medical care because of how difficult it is to enroll in the "right" Medi-Cal program at the "right" time. They also risk not being able to continue seeing their prenatal care providers or deliver in the hospital they've been planning on due to unnecessary state-- not federal-- eligibility rules that require their "aid code" to be switched during pregnancy under certain situations. Addressing these issues would not only promote healthy birth outcomes and save taxpayer dollars by avoiding preventable medical complications during pregnancy and childbirth, it would also allow for more effective use of an electronic process for enrolling pregnant women into Medi-Cal early in pregnancy and retaining coverage throughout. While we have emphasized examples affecting pregnant women here, other Medi-Cal eligibility categories and eligibility rules call out for simplification as well.

There is also the need for assistance with the "on-going" case: the CPR recommendation seems not to account for this at all. It is not enough to enroll eligible people into the four targeted programs: eligibility must be retained at critical reporting junctures, and we find in our work that health consumers frequently need labor-intensive assistance with this. Does the CPR recommendation factor in the need for processing reported changes, as Medi-Cal beneficiaries are required to do within 10 days of a change? Will the administratively burdensome Medi-Cal mid-year status reporting (MSR) requirement recently adopted by the state-- even though it is *not* required by federal law-- be dropped? And if the MSR requirement is retained, where will these Medi-Cal reports and the federally required annual eligibility reviews (also required in Healthy Families) be processed and by whom? **How will individual consumers be able to solve the difficulties that are often encountered at each of these "redetermination" points?** Inadequate outreach is only part of the reason why hundreds of thousands of eligible California children are not enrolled in Medi-Cal or Healthy Families: unnecessarily burdensome reporting and retention requirements also contribute to eligible children's uninsurance.

We are also disappointed that the CPR does not address the major barrier to retaining children's health insurance that results from separating the Medi-Cal and Healthy Families funding streams. Low-income working parents often experience fluctuations in their incomes; under the existing Medi-Cal and Healthy Families eligibility rules, the children in many of these families switch back and forth and back again between the two programs every twelve months, a disruptive and ineffective way to operate children's health insurance programs. The current system is also incredibly administratively inefficient, as it requires the maintenance of two separate bureaucracies in two separate state administrative agencies. **Consideration should be given to folding all of children's health insurance funding into a single, new program, with a new name, in which**

families would pay premiums and co-pays based on the existing Healthy Families scale according to income level. New York's combined Medi-Cal/S-CHIP children's health insurance program could be a model to study here.

No enrollment model is perfect: significant assistance capacity will always be required. If technology plays a larger role in processing Medi-Cal and Healthy Families applications, glitches and even major system-wide problems are likely to arise, potentially affecting millions of people over extended periods of time. **The experience with the Healthy Families privatization model is anything but reassuring in this respect**.

Significant problems enrolling children have dogged the Healthy Families program since its inception, and these problems have not disappeared with the change to a different private contractor in the fall of 2003 to operate the state's "single point of entry" (SPE). This state-level call-in and mail-in center receives applications for Healthy Families and for Medi-Cal for children and pregnant women (applying through the SPE is mandatory for Healthy Families, optional for Medi-Cal). Widespread problems with the SPE have led the Healthy Families Advisory Panel to ask that *local* phone contact numbers be provided to assist applicants who cannot get through to the state number to learn the status of their Healthy Families applications or address other issues to complete the application process.

While progress in addressing some application barriers has been made through intensive advocacy over the past year, following are examples of the kinds of problems that continue to occur and which have been reported to staff of the Managed Risk Medical Insurance Board (MRMIB) as well as to the Board itself at public hearings:

- Lost applications
- Long delays in processing initial applications and annual eligibility reviews
- Inability to assist callers resolve problems with submitted applications or annual review forms
- Inconsistent or inaccurate information provided, or no response at all, for applicants, enrollees and advocates with general questions or who are trying to resolve problems with their specific applications
- Mistakes in processing Healthy Families applications resulting in incorrect eligibility denials
- Lack of clear information and a timely process for resolving problems and handling Healthy Families appeals

> **CPR Recommendation B (HHS 01):** *The state should adopt a self-certification process for the assets test for applicants other than the aged, blind and disabled.*

MCHA Comment: The assets test should be dropped entirely, pursuant to the existing federal option under the Section 1931(b) program for very low-income families with children, and in Food Stamps and CalWORKs as well. MCHA would not object to self-certification, but we stress that if the CPR's goals are to better serve people while making state programs operate more efficiently, dropping the assets test is the better approach.

> **CPR Recommendation C (HHS 01):** *The State of California should have a public awareness program component for the transition to an Internet-based eligibility system.*

MCHA Comment: MCHA agrees that a transition period would be required for *any* major structural change in how eligibility is done in any of the four targeted programs. But it seems premature to comment on what the public awareness campaign should include, or how much it should cost (the CPR recommends $36 million a year), until the many major policy issues raised above are effectively addressed.

> **CPR Recommendation D (HHS 01):** *The State should pay a one-time application assistance fee of $50 for all four programs to certified application assistants which will enhance community-based assistance with the application process.*

MCHA Comment: Several of MCHA's staff members are certified application assistors (CAAs). We also train other community-based CAAs and staff of other community-based organizations (CBOs) on all of the publicly-funded health care programs available in L.A. County. We have watched with concern the data reports indicating a rise in incomplete and inaccurate applications being submitted to the SPE since state support for the outreach and enrollment activities of CAAs was withdrawn. We support the intent of the CPR recommendation to make application assistance available in the community to assist families applying for any of the four targeted programs.

However, to ensure quality assistance for consumers, MCHA believes three principles are fundamental:

> (1) "Assistance" must mean not just filling out and submitting an application, but helping the client and his or her family for as long as it takes to get the correct eligibility determination *and* learn how to use the

coverage they've been granted to access quality health services, especially when in a managed care environment;

(2) There must be effective and on-going training, oversight, and monitoring of the CAA corps to ensure that comprehensive quality assistance is in fact being provided; and

(3) The funding mechanism for such assistance must include grants to non-profit CBOs to sustain a high quality outreach and enrollment infrastructure genuinely integrated with community institutions.

Given the importance of these principles, we have major concerns with the recommendation to support application assistance solely through a one-time $50 fee, especially if the Food Stamps and CalWORKs applications are consolidated with the ones for Medi-Cal and Healthy Families.

CAAs should be truly community-based and connected to nonprofit enrollment entities to enhance oversight and monitoring and thereby improve quality. Some MCHA clients have encountered unscrupulous individuals pretending to be CAAs who have demanded payment for their assistance directly from the consumer and may have never even sent the application in for processing. Others of our clients have been told by CAAs that they have no choice but to enroll in a Medi-Cal managed care plan during pregnancy, which is not the case for most women in L.A. County.

Even when there is no ill-intent or incompetence, **relying on the $50-per-application fee to support assistance leads to poor quality in assistance services.** When the $50-per-application fee was available for Medi-Cal and Healthy Families several years ago, insurance agents received the most fees; these and other individuals, however, cannot realistically be expected to attend trainings to keep up-to-date about the many ways that the eligibility requirements and the application process for Medi-Cal and Healthy Families change.

> **CPR Recommendation E (HHS 01):** *The state entity responsible for the contract should be authorized in state statute to receive the same contracting authority as is now granted to the California Medical Assistance Commission, the Managed Risk Medical Insurance Board and Medi-Cal managed care contracts.*

MCHA Comment: In view of the many points raised above, this recommendation strikes us as premature. It seems that a broad range of important policy issues needs to be resolved before contracting authority for the responsible state entity can be considered and addressed in a meaningful way.

We also understand that in Texas and Florida, where privatization of eligibility determinations for public benefits programs has been under consideration, private bidders and state officials have been implicated in serious contracting fraud allegations, underscoring the need for careful, deliberate decisions about contracting authority should any aspect of the CPR privatization recommendations go forward in California.

HHS 28 Medi-Cal "Smart Cards" and Finger-Imaging

MCHA Comment: Finger-imaging of Medi-Cal beneficiaries as part of the "smart card" process (discussed at CPR p. 460) would be counterproductive to the CPR's stated goals of making government serve people better, operate more efficiently, and eliminate unnecessary administrative costs. Ironically, as the CPR itself points out, Medi-Cal fraud is perpetrated primarily by providers, and one of the recommendations, HHS 31 (Medi-Cal Fraud Targeting Misses the Mark), is even based on the need to better target the state's anti-fraud efforts among providers.

Finger-imaging would further stigmatize Medi-Cal consumers and deter applications without contributing to the state's anti-fraud efforts. "Why," applicants may well wonder, "is finger-printing required in Medi-Cal but not Healthy Families? Does the state think I'm a criminal for applying for Medi-Cal for myself or my children? What will the state do with my finger-prints—report me or my children for deportation?" It is not likely that even expensive "public education" campaigns will allay such fears.

Finger-imaging in Medi-Cal would also add to, not alleviate, administrative burdens for consumers, who would have to go through the additional step of having their finger-prints taken in person. And parents enrolling just their children would have to provide their own prints, according to the report (p. 460): will the working poor have to take time off work to appear in person to be fingerprinted, losing income they don't have to spare? Legal guardians would also have to provide their own prints for the elderly under their charge (*id*.): such administrative burdens and privacy invasions for family members would make Medi-Cal less, not more, consumer-friendly.

HHS 27 Automate Identification of Other Health Coverage

As we understand it, this recommendation would require that the current process by which the counties transfer information about a Medi-Cal beneficiary's "other health coverage" (OHC) to the State Department of Health Services (or successor

entity) would be automated and would interface with the current automated process the state uses to locate OHC.

MCHA Comment: **However, under this recommendation beneficiaries enrolled in Medi-Cal managed care plans would be immediately disenrolled from the plan, once OHC is located. Yet pregnant women and other Medi-Cal beneficiaries remain eligible for Medi-Cal for services not covered by whatever OHC they may happen to have**, such as drugs and obstetrics, as the CPR report acknowledges (at p. 453.) The CPR recommendation to automatically disenroll beneficiaries from their Medi-Cal managed care plans without first assessing what benefits the OHC excluded and how the disenrollment from a health plan could affect the individual's continuity of care would create more problems than it solves. The CPR recommendation is also silent as to how the former plan enrollee's Medi-Cal would be delivered, if at all. **At a minimum, a process is needed for ensuring that pregnant women and others in a course of care in Medi-Cal managed care plans do not have their medical services disrupted and that due process is provided.**

HHS 30 Medi-Cal TARs

The CPR recommendation here is to consolidate all of the Medi-Cal Field Offices at one central location and use technology to process Treatment Authorization Requests (TARs).

MCHA Comment: Without more detail about how this would affect access by consumers, through their providers, to the TAR process, it is not possible to provide meaningful comment here.

We do take this opportunity to urge the Director, Secretary, and the Commission to give serious consideration to the recommendations made during the Medi-Cal Redesign working group process to reform the TAR requirements themselves. Specific recommendations are set forth in *Medi-Cal Treatment Authorizations and Claims Processing: Improving Efficiency and Access to Care* (July 2003) by the Medi-Cal Policy Institute (www.chcf.org/documents/policy/MediCalTARandClaims.pdf). **Key among these is to reduce the number of services that require TARs at all**—an approach that would be consistent with the fact that about 80% of procedures requiring TARs are usually ultimately allowed in any event (estimate provided by Department staff at working group meeting.) Given the CPR's stated goals of eliminating waste, doing away with a senseless paper chase that only makes it harder for providers to do their jobs and for consumers to receive the medically necessary care to which they are entitled should be at the top of the list of reforms.

HHS 23 Medical Survey/Health Plan Audits

CPR Recommendation: *The Governor should work with the Legislature to require the state to use the results from accrediting organizations where they are equivalent to or exceed the state's standards regarding medical surveys/audits of health plans. This legislation should permit health plans voluntarily accredited by approved organizations to be exempted from routine surveys and audits by DHS and DMHC; authorize the state to monitor the procedures of the accrediting organization; and require approval of state officials before accepting the accrediting organization's review in lieu of the state's own review.*

MCHA Comment: It is difficult to reconcile this CPR recommendation with consumer-driven policy initiatives in California requiring truly independent oversight of health care plans. To eliminate duplication in reviews, if any exists, the private accrediting organizations could accept the independent public reviews. Consumer-protection should be paramount when it comes to ensuring quality of health care, not industry convenience.

HHS 02 Realigning (County Health Services)

Among the several realignment recommendations in the CPR is "reliev[ing] the counties of the responsibility for indigent health care and transfer[ring] responsibility for funding and administering the Medically Indigent (MIA) program to the state" (p. 277).

MCHA Comment: The need to provide quality health care services to the over six million Californians who are uninsured is urgent. **MCHA would strongly support restoring the responsibility for MIA care to the state, if the MIAs' eligibility for the Medi-Cal program is also restored**. Re-integration into Medi-Cal (which included the MIAs before 1983) would ensure statewide uniformity in eligibility requirements and scope of benefits for MIAs throughout California; it is difficult to see how any other transfer arrangement would guarantee equity and access to the necessary level of care.

As noted in the CPR report, including the MIAs in Medi-Cal would also open up possibilities for drawing down federal matching funds to support MIA care. The terms and conditions for such federal waiver funding, however, would have to be carefully considered by members of the public and the Legislature.

HHS 10 $50 Child Support Disregard Payments

MCHA Comment: The result of this CPR recommendation here, i.e., to eliminate the $50 child support disregard payments for families participating in CalWORKs, would be to deprive California's neediest families of a significant portion of their income. No improvement in health status can come of the proposal: quite the opposite should be expected to occur, as many studies have shown that poverty undermines health status. **We perceive great harm to parents' and children's health from this recommendation and urge that it be rejected.**

Sincerely,

Lynn Kersey, MA, MPH
Executive Director

Lucy Quacinella, Esq.

cc: S. Kimberly Belshé, Secretary, CHHS
California Performance Review Commission